Illinois State Partnership Exchange Blueprint Application

3.14 - Pre-Existing Conditions Insurance Plan (PCIP) Transition Plan – The Exchange will follow procedures established in accordance with 45 CFR 152.45 related to the PCIP transition. Evidence should include and/or address the transition plan for State-based PCIP programs.

In March 2012, HHS issued the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule. This rule in section 155.345 (h) (2) (i) describes the transition for PCIP enrollees to the Exchanges. This section states that the Exchange must follow procedures established in accordance with 45 CFR 152.45 to transition PCIP enrollees to the Exchange to ensure that there are no lapses in health coverage.

In August 2012, HHS advised all state PCIP contractors that the transition process will occur during the fourth quarter of 2013. Each state has been notified that it is their responsibility to send out three mailings to each enrollee in the PCIP plan and Illinois will follow this guidance. The mailings will include information regarding Illinois assisters and their phone numbers for enrollees to contact to discuss the transition process. Additionally, Illinois will implement Exchange on-boarding activities funded through the Exchange grant, including proactive outreach and enrollment by assisters to facilitate a smooth transition to Exchange coverage. Illinois will also have additional personnel for the PCIP call center to answer questions and help transition enrollees to the Exchange. Illinois will amend the PCIP website to include all necessary Exchange/transition information.

By federal statute, PCIP programs will extend coverage only for the cost of covered services up through December 31, 2013, unless funds are exhausted prior to that date. The Exchange Qualified Health Plans (QHPs) will be responsible for all covered services for enrolled individuals enrolled starting on January 1, 2014, including any on-going treatments, such as inpatient services.

To this end, the Affordable Care Act stipulates enrollee coverage under PCIP programs ends effective January 1, 2014 because coverage will be available under the Exchanges and insurance plans will no longer be permitted to exclude coverage for preexisting conditions. HHS, in accordance with the ACA, allows for run-off of all PCIP programs by June 30, 2015. Illinois is already implementing these changes. The Illinois PCIP plan booklet states that claims must be filed within 12 months and that any outstanding claims at the close of the Plan on December 31, 2013 will be subject to a close out period that will run through June 30, 2015, “but in no event will be payable once federal funding is no longer available.”

4.1 - Appropriate Authority to Perform and Oversee Certification of QHPs – The Exchange has the appropriate authority to perform the certification of QHPs and to oversee QHP issuers consistent with 45 CFR 155.1010(a). Evidence should include a citation of the State’s applicable statutory and/or regulatory authority(ies).

The Illinois Department of Insurance (DOI) has this authority under the broad powers granted to the Director under 215 ILCS 5/401. Section 5/401 states, “the Director is charged with the rights, powers and duties pertaining to the enforcement and execution of all the insurance laws of the State.” Section 5/401(a) states that the Director shall have the power “to make reasonable rules and regulations as may be necessary for making effective such laws.”

4.2 - QHP Certification Process – The Exchange has a process in place to certify QHPs pursuant to 45 CFR 155.1000(c) and according to QHP certification requirements contained in 45 CFR 156. Evidence should include and/or address the following: 1) Description of how the appropriate State entity will ensure that issuers and health plans meet each of the QHP certification standards, including the process the appropriate State entity will use to evaluate issuers and health plans against each of the QHP certification standards, and any differences specific to SHOP, 2) Description of the entities responsible for QHP certification, including a description of roles and responsibilities of each entity as they relate to each of the QHP certification standards, and 3) Description of the integration between the Federally-facilitated Exchange and the State Department of Insurance.

- ***Capacity to certify QHPs in advance of the annual open enrollment period pursuant to 45 CFR 155.1010(a)(1) (4.2a)***
- ***Capacity to ensure QHPs comply with the QHP standards contained in 45 CFR 156, including but not limited to standards relating to licensure, solvency, service area, network adequacy, essential community providers, marketing and discriminatory benefit design, accreditation, and consideration of rate increases (4.2b)***
- ***Capacity to collect, analyze, and if required, submit to Federal government for review of QHPs' plan variations for cost-sharing reductions, advance payment estimates for such reductions, and any supporting documentation needed to ensure compliance with applicable regulations and accuracy of the cost-sharing reduction advance payments (4.2c)***
- ***Capacity to ensure QHPs meet actuarial value and essential health benefit standards in applicable regulations and guidance (4.2d)***
- ***Capacity to ensure QHPs' compliance with market reform rules in accordance with all applicable regulations and guidance (4.2e)***

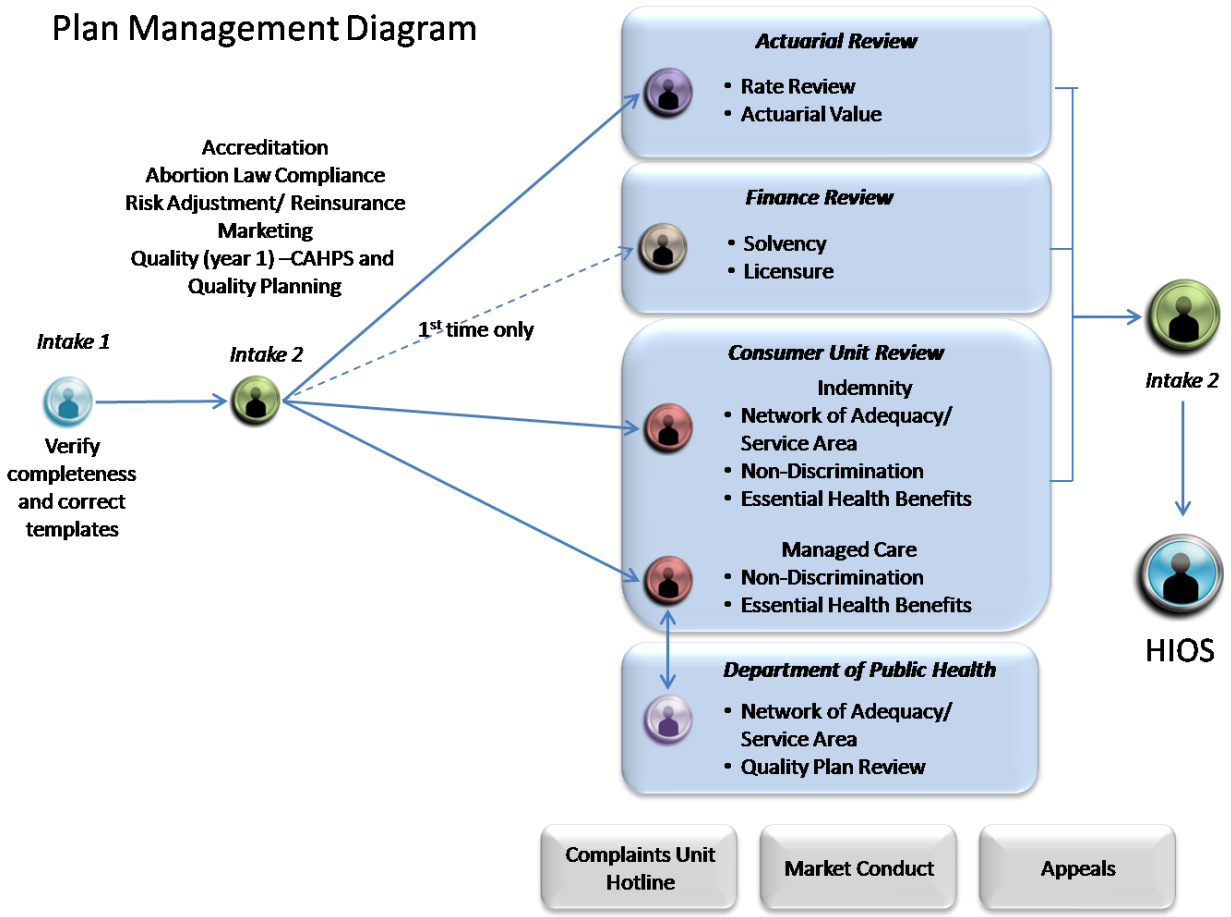
4.2a - Capacity to certify QHPs in advance of the annual open enrollment period pursuant to 45 CFR 155.1010(a)(1).

The following procedure will be implemented by the DOI to recommend QHPs to CCIIO for certification by June 21, 2013 in advance of the annual open enrollment period.

1. Health insurance carriers will complete the QHP application and submit it with supporting documentation through SERFF to DOI.

2. DOI regulators will review QHP applications. The diagram below displays the workflow of the QHP certification process between various Divisions, including coordination between DOI and the Department of Public Health (DPH) for managed care plan review.

    a. A DOI Office Associate (Intake 1) will open the filing and check it for completeness, including the use of required templates. A second Office Associate (Intake 2) will use an internal checklist to verify that specific criteria, such as the inclusion of a quality plan and abortion law compliance, are met. The second Office Associate (Intake 2) will then assign various parts of the application to the appropriate DOI regulators for review. The second Office Associate (Intake 2) will monitor filings from each unit to determine the QHP certification process is progressing in a timely manner.



3. DOI recommends QHPs for certification to CCIIO by June 21, 2013 through the federal Health Insurance Oversight System (HIOS). If DOI determines that a QHP applicant does not meet minimum standards, the applicant will have access to a formal appeal process.

4. DOI will conduct oversight of federally-certified QHPs on an ongoing basis based on complaints and both scheduled and ad hoc market conduct examinations.

4.2b – Capacity to ensure QHPs comply with the QHP standards contained in 45 CFR 156, including but not limited to standards relating to licensure, solvency, service area, network adequacy, essential community providers, marketing and discriminatory benefit design, accreditation, and consideration of rate increases.

Compliance with QHP standards will be checked when the policy forms are filed. DOI regulators will evaluate issuers and health plans against each of the QHP standards to determine which QHPs should be recommended to CCIIO for certification as follows:

Annual Information Submission: SERFF will be used to collect Exchange applications and related documents from QHPs. Carriers will need to submit QHP applications to DOI through SERFF by March 1, 2013. If the National Association of Insurance Commissioners (NAIC) enhanced System for Electronic Rate and Form Filing (SERFF) is not ready in time, DOI hopes to leverage a plan management solution built by the Exchange (HIX) Vendor as a SERFF wrap-around with full plan management functionality.

QHP Recommendation for Certification: DOI will consider DPH's comments in regards to meeting the QHP requirements and will ensure that all plans meet federal and state standards for solvency, licensure, network adequacy, quality, etc. DOI will expand the capacity of its current regulatory teams to ensure it is equipped to handle the additional workload, including 4 Health Analysts for compliance/policy forms/rate filings; 4 Health Analysts (2 complaints; 2 Office of Consumer Health Insurance (OCHI)); 1 Actuarial Assistant; 1 Health Actuary; 1 Office Coordinator (triage/intake); 2 Market Conduct Examiners; 2 Attorneys; and 1 Research Economist. Likewise, DPH will add 1 Registered Nurse to expand review capacity for HMO network adequacy and quality.

Additionally, the HIX Vendor will help DOI automate its current system to help reduce and manage staff workload. DOI is anticipating that the HIX Vendor will provide full plan management functionality by leveraging SERFF (which only includes partial functionality) and integrating additional functionality through its proposed system. Illinois is currently evaluating bids on its HIX RFP and will not know additional details on the HIX plan management system until a Vendor is chosen and a contract is negotiated. DOI expects the contracting process to be complete by the end of 2012, at which point additional details on system functionality will be available and shared with CCIIO.

Licensure: Illinois statute 215 ILCS 125/2-1 and 215 ILCS 5/121 currently requires any health care plan issuer in Illinois to be licensed and in good standing with the State. To register, carriers must submit information regarding their financial condition, identity, and relationships of insurance holding company system members; agreements and relationships with affiliates regarding loans, exchanges of assets, transactions, etc.; management and service contracts and all cost-sharing arrangements; reinsurance agreements; pledges of the company's securities and securities of subsidiaries or affiliates to secure a loan; and consolidated tax allocation agreements. No changes need to be made as this process is currently in compliance with federal standards. The Financial Corporate Regulatory Division will review QHPs for licensure.

Solvency: DOI regulators will monitor solvency by review of financial statements required by Part 925 of Title 50 to the Illinois Administrative Code. Through the use of the NAIC Financial Analysis Handbook, DOI performs annual reviews and quarterly reviews as well as the review of other information and data to discern potential and actual financial problems of each domestic insurance company by assigned analysts.

Review sheets are also prepared on supplemental filings. More detailed reviews are completed as necessary. Senior Analysts and/or Unit Supervisors review these documents and make the appropriate recommendations with in-depth probing and challenging comments. An NAIC Level 1 analysis is completed for each company and a Level 2 analysis is completed as needed. Additionally, insurer profiles are completed and updated annually and quarterly and a holding company analysis is completed annually. Companies are contacted for additional information as necessary.

DOI reviews the following for all domestic and multi-state companies:

- Annual Statement
- Actuarial Opinion
- Management's Discussion and Analysis
- Annual Audited Financial Statements
- Holding Company Filings

- Premium projections for QHP total combined individual and small group
- Quarterly Statements (Key Financial Data)
- Financial Ratios and NAIC Financial Analysis Solvency Tools (Scoring System and Insurance Regulatory Information System Ratios)
- Other Tools, including Risk Based Capital and Trend Analysis

These guidelines are subject to change in order to remain in compliance with NAIC Accreditation Standards. The Financial Corporate Regulatory Division in DOI will review QHPs for solvency and will monitor financially challenged entities on a quarterly basis. If the company is not adhering to the applicable laws and rules, DOI can issue a stipulation and consent order, a corrective order, or an order of suspension.

Product Pricing, Rating Variation, and Plan Rating: Through review by DOI actuaries and insurance regulators, DOI will ensure that QHPs offered through the Exchange have the same premium and cost-sharing rates as the same plans offered outside of the Exchange; that issuers vary premiums only in accordance with permitted rating variations; and that issuers cover all groups using some combination of individuals, two-adult families, one-adult families with a child or children, and all other families. DOI will review initial rate filings and rate increase filings for QHPs to see that sound assumptions and methodologies were used in developing QHP premium rates. DOI will also review rates for compliance with relevant ACA requirements. The Life Actuarial Section of the Financial-Corporate Regulatory Division in DOI will review the product pricing.

DOI is currently working to define geographic rating areas and is awaiting additional guidance from HHS on this issue to ensure that its rating areas are in compliance with federal regulations. DOI will work with the Secretary to ensure the adequacy of the areas once they are established. DOI currently plans to utilize the Illinois Comprehensive Health Insurance Plan rating areas and is evaluating if Chicago should be included in the same rating area as Cook County and the Collar counties. The Life Actuarial Section in DOI will review rating areas and the additional staff noted above will ensure DOI has the appropriate regulatory capacity.

Additionally, 215 ILCS 5/424(3) provides, "making or permitting in the case of insurance of the types enumerated in Classes 1, 2, 3 and Section 4 [215 ILCS 5/4], any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants. The application of this Article to the types of insurance enumerated in Class 1 of Section 4 shall in no way limit, reduce, or impair the protections and remedies already provided for by Sections 236 and 364 or any other provision of this Code." Section 364 also prohibits discrimination between individuals of the same class of risk in the issuance of policies or in the amount of premium or rates charged in connection with accident and health insurance.

Rate Review: Rate submissions are required under 215 ILCS 5/355. Rates will be submitted through SERFF. QHP rates must be set for an entire benefit year in the individual Exchange and for the plan year in the SHOP Exchange. In the SHOP Exchange, rate changes must be submitted to DOI for review. The current rate review process will continue to be followed for all rate changes. DOI will continue to collect rate filings and actuarial memorandums electronically through its rate review web portal. DOI will evaluate the medical and insurance trend assumptions, anticipated loss ratio, anticipated distribution of business, contingency and risk margins, past and anticipated premium and claim experience, the history

of rate adjustments, and other important data points submitted through the web portal as required by DOI. DOI will notify CCIIO of the rate review results within the QHP recommendation.

Additionally, the rate review process will be updated to take into consideration new payments and charges to plans, including risk adjustment, reinsurance, risk corridors, the coverage of new populations and benefits, new underwriting limitations, MLR rebates, new federal taxes, and new risk pooling in non-grandfathered plans. DOI will verify that the "same premium rate" is offered inside and outside the Exchange for the same plans. The rate review processes will be applied consistently for multi-state plans and CO-OPs to maintain a level playing field. The Financial-Corporate Regulatory and Life Actuarial Divisions in DOI will conduct rate review and will involve the Consumer Markets/Compliance unit to ensure DOI has the appropriate regulatory capacity.

Risk Adjustment and Offering Requirements: DOI will leverage SERFF or its separate HIX IT plan management solution to accept evidence of risk adjustment compliance. Because the federal government will be operating risk adjustment in Illinois, the State will also establish, through SERFF or the HIX IT solution, any necessary connections with HHS or the Federal Hub to ensure ongoing compliance with this requirement.

DOI will also utilize SERFF or its separate HIX IT solution to check for compliance with offering requirements during its QHP review process. Requirements examined will include the offering of at least one QHP in the silver tier and gold tier, as well as at least one child-only plan (or separate child-only rates) in each of these tiers. In confirming these determinations, Illinois will leverage the forthcoming HHS Actuarial Value calculator. The Financial-Corporate Regulatory and Life Actuarial Divisions in DOI will review offering and risk adjustment requirements. Additional staff noted above will ensure DOI has the appropriate regulatory capacity.

Third-Party Accreditation: Under a partnership Exchange, Illinois will follow federal standards and the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) will accredit QHPs. DOI plans to be electronically advised of any changes in QHP accreditation status through SERFF or the HIX Vendor's plan management solution, which will track QHP accreditation status.

Service Area and Network Adequacy: Under the review process for QHPs, the plan must ensure that any plan which encompasses a provider network is sufficient in number and types of providers, including mental health and substance abuse providers and essential community providers, to assure all services are accessible without unreasonable delay. This review will be completed by the Consumer Unit. To ensure these requirements are met DOI will require each QHP applicant to file policy forms and other necessary documentation for review to verify compliance with the Network Adequacy and Access requirements, including:

QHP PPO Requirements-50 IL Admin Code 2051.310/Appendix C

- 24/7 Accessibility
- Geographic Map with Providers Marked
- List of Provider Names, Addresses, and Specialties
- Number of Anticipated Beneficiaries
- Internet website and toll-free telephone number for beneficiaries to access up to date providers lists

- Ratio of Providers to Beneficiaries
- Greatest Travel Distance
- Inadequate Networks
- Policies for Closing and Opening New Providers
- Referral Procedures
- Identification Card Requirements
- Special Communication Needs
- Gatekeeper Option if Applicable

The QHP application review checklist will require essential community providers (ECPs) to be included in the network filing and submitted to DOI for review as a geoaccess map. The carrier will also be required to certify the inclusion of these providers in the directory. DOI will ensure plans have a sufficient number and type of essential community providers with in the plan service area by reviewing the geoaccess map compared to the number and type of essential community providers in the plan's service area. This evaluation may include discussions with the QHP applicant. DOI will measure appropriateness on a case by case basis in plan year one and is considering developing additional standards in future years through collaboration with DPH and after further analysis and evaluation of ECP availability throughout Illinois.

Additionally, DPH will review the network adequacy and quality components of HMO QHP applications and provide a recommendation to DOI on if the HMO applicant meets these standards. DPH will ensure the HMO has a sufficient number of primary care physicians (PCP) and specialists with hospital admitting privileges at participating facilities who are accessible 24 hours per day, seven days per week within the HMO's service area; the number and location of providers and facilities must be readily available and accessible within the geographical service area to all enrollees. Additionally, the HMO must have an agreement with at least one hospital located in each geographic county; if the county does not have a hospital, it must have an agreement with a hospital in a county that is contiguous to the service area. In urban areas, the distance from any point in the HMO's service area to a point of service can be no greater than 30-45 miles for primary care, OB-GYN, and general hospital care and 45-60 miles for specialists. In rural areas, the distance from any point in the HMO's service area to a point of service can be no greater than 60-100 miles for primary care, OB-GYN, and general hospital care and 75-100 miles for specialists in rural areas. The provider to enrollee ratio must be 1 per 1,000 for PCPs; 1 per 10,000 for Cardiology; 1 per 10,000 for Gastroenterology; 1 per 5,000 for General Surgery; 1 per 20,000 for Neurology; 1 per 2,500 for OB/GYN; 1 per 15,000 for Oncology; 1 per 10,000 for Ophthalmology; and 1 per 10,000 for Urology. DPH will also review a geoaccess map for a sufficient number and type of essential community providers.

Any material changes or additions to the provider network for all QHPs must be reported to the Director within 30 days after the end of the month of each change or addition. The change is required to be filed in accordance with the procedures of a form filing in SERFF. All complaints and inquiries will be monitored for compliance with network adequacy requirements. Customer satisfaction surveys may be established to provide further surveillance.

Additionally, both URAC and NCQA have standards for network adequacy and access, and DOI will leverage the review process conducted by these organizations as plans complete the accreditation process. URAC requires the plan to set, maintain, and continuously monitor network adequacy goals to ensure enrollees have timely access to needed services. The URAC accreditation process includes a desk

top review of the plan's network composition capacity plan and the number of contract providers by name, location, and type. The URAC on-site review validates the plan if the plan is meeting the network and access goals. NCQA provides accreditation by product type. NCQA reviews whether issuers' policies and procedures include measurable standards for the number of each type of provider, including primary, specialty, and behavioral health care. DOI also looks at whether plans are analyzing performance against their defined standards. The Department will continue to review required network adequacy requirements and then supplement them with the URAC and NCQA standards once a QHP plan is accredited.

Additionally, carriers will certify that the plan will cover health care services without discrimination against any beneficiary on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability. 50 Ill. Adm. Code 2051.290(j) within the QHP application.

Minimum Coverage, Essential Health Benefits, and Actuarial Value Tiers: Title 50 Section 2007.10 states that no individual policy shall be delivered or issued for delivery which does not meet the required minimum standards for the specified categories, and Section 2007.10 will be updated to ensure that the minimum benefit standards outlined in state law comply with federal standards.

DOI will ensure that QHPs provide coverage for the essential health benefits by leveraging the CCIIO AV calculator. DOI actuaries also will review and approve actuarial explanations for plans that do not use the AV calculator due to unique benefit designs. Furthermore, for all QHP applications, DOI will evaluate that AV substitutions are non-discriminatory through review by actuaries in the Financial-Corporate Regulatory and Life Actuarial Divisions in DOI.

DOI actuaries will also ensure that cost-sharing limits and specified metal level designations of coverage are appropriate. QHPs will be required to offer plans in at least the silver and gold coverage level, as well as at least one child-only plan or rate at the same level as its other QHPs.

The Financial-Corporate Regulatory and Life Actuarial Divisions in DOI will review that QHPs meet actuarial value tier standards and the Health Products Division within DOI will review essential health benefit standards. DOI will rely on the federal government for exemptions from the individual and employer responsibility requirements.

Quality Standards: The Illinois Managed Care Reform and Patient Rights Act, 215 ILCS 134/1 *et seq.* requires the development of a quality improvement initiative, and related reporting, to identify and evaluate accessibility, continuity, and quality of care under 215 ILCS 134/80. The quality plan must include an ongoing, written, internal quality assessment of the program; guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees, including accessibility to health care providers, appropriateness of utilization, concerns identified by the plan's medical or administrative staff and enrollees, and other aspects of care and service directly related to the improvement of care quality; corrective action plans to correct quality problems; and follow-up measures to evaluate the effectiveness of the action plan, including a committee that oversees the quality assessment and improvement strategy and includes physician and enrollee participation and produces quarterly reports. HMOs may submit proof of accreditation from NCQA, URAC, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or other entities DPH approves as evidence of a quality management strategy, allowing the plan to be "deemed" in compliance with

quality standards by DPH. This policy will be expanded to apply to PPOs, which will be required to include a quality plan in the QHP application.

Illinois requirements will be updated to meet federal quality standards including requiring QHP issuers to report annually to HHS on quality improvement strategies, disclose and report information on health care quality and outcomes, and include in quality outcome reporting pediatric quality reporting measures established under Section 1139A of the Social Security Act. Additionally, each QHP that has more than 500 enrollees in the previous year will be required to offer a consumer satisfaction survey that is developed by HHS, and the information will be provided to individuals and employers on the Exchange website to assist in QHP comparison.

The quality review process will be coordinated with DPH. DPH will review quality standards from HMOs and make a recommendation to DOI, including notification to DOI of a lack of compliance. Only DOI will review PPOs. DOI will be responsible for leveraging penalties for both HMOs and PPOs. The Consumer Unit in DOI will review QHPs for quality standards. DPH will provide additional support by reviewing HMO quality plans and submitting recommendations to DOI.

Marketing Standards: Marketing standards will be the same inside and outside the Exchange to reduce the risk of adverse selection. QHPs will be required to comply with state marketing laws and may not employ marketing practices that discourage enrollment of individuals with significant health needs. Current Illinois marking standards are spelled out in Sections 5/149 and 5/364 of the Illinois Insurance Code and Part 2002 of the Department's administrative regulations (50 Ill. Adm. Code 2002). These standards are set to ensure that marketing activities are fair and accurate. The standards include provisions for required and prohibited language, requirements for filing of marketing material, provision of educational material, an explanation of the policy features.

DOI will modify Title 50 §2002.30 to reflect the uniqueness of adding an Exchange to the marketplace. Currently Title 50 §2002.30 states "this Part shall apply to any accident and sickness insurance 'advertisement' as that term is hereinafter defined in Section 2002.40, unless otherwise specified in this Part, intended for presentation, distribution or dissemination in this State when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent or broker." This regulation will be amended to include reference to "advertisements" both inside and outside of the Exchange, as well as to add a requirement that the issuer submit proof of compliance annually to the DOI. Additionally, DOI will specify that products and rates must not be constructed or marketed in a way that discourages people from using the Exchange.

DOI will audit random samples and monitor consumer complaints and Navigator reporting to evaluate compliance, similar to using SHIP volunteers for compliance and fraud reporting. The Compliance Division in DOI will conduct appropriate oversight throughout the year.

Non-Discrimination: For benefit design and marketing, DOI and DPH regulators will check to ensure that issuers do not discriminate based on race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Non-discrimination will be evaluated during the assessment of service area, network adequacy, essential health benefits, and marketing. Complaints will be evaluated to further ensure that discrimination is not occurring in plans in the marketplace. Non-discrimination standards already exist in current state insurance regulations. 215 ILCS 5/424(3) provides, "[m]aking or permitting in the case of insurance of the types enumerated in Classes 1, 2, 3 and Section 4 [215 ILCS 5/4], any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and

expense element because of the race, color, religion or national origin of such insurance risks or applicants. The application of this Article to the types of insurance enumerated in Class 1 of Section 4 shall in no way limit, reduce, or impair the protections and remedies already provided for by Sections 236 and 364 or any other provision of this Code."

Additionally, Section 364 prohibits discrimination between individuals of the same class of risk in the issuance of policies or in the amount of premium or rates charged:

- "Discrimination between individuals of the same class of risk in the issuance of its policies or in the amount of premiums or rates charged for any insurance covered by this article, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever is prohibited. Nothing in this provision shall prohibit an insurer from providing incentives to utilize the services of a particular hospital or person."

- "No company, in any policy of accident or health insurance issued in this State, shall make or permit any distinction or discrimination against individuals solely because of handicaps or disabilities in the amount of payment of premiums or rates charged for policies of insurance, in the amount of any dividends or other benefits payable thereon, or in any other terms and conditions of the contract it makes."

- "No company shall refuse to insure, or refuse to continue to insure, or limit the amount or extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses his or her eyesight."

In addition, 215 ILCS 5/351B-4(i) prohibits "discrimination between individuals of the same class of risk in the issuance of policies, in the amount of premiums or rates charged for any insurance covered by this Article, in benefits payable thereon, in any of the terms or conditions of the policy, or in any other manner whatsoever is prohibited."

While reviewing forms, DOI insurance analysts will review for discriminatory language and require any discriminatory language be removed from the forms. The insurance analysts also determine if there is discriminatory language contained in the policy filing. The Compliance Division of the Consumer Unit will review QHPs for discrimination.

Abortion Law Compliance: Abortion services are governed by two existing Illinois statutes, 215 ILCS 5.356z.4 and the Illinois Abortion Law of 1975. Section 5.356z.4, which regulates coverage for contraceptives and includes a provision that states that "nothing in this section shall be construed to require an insurance company to cover services related to an abortion." The Illinois Abortion Law of 1975 as set forth in 720 ILCS 510 outlines the circumstances within which an abortion can be performed, and lays out any penalties for violating those provisions. Section 1 of the Illinois Abortion Law aims to regulate abortion services based on the Supreme Court decision of January 22, 1973 (Roe vs. Wade) while holding firm to the existing policy of the State. All current health plans must abide by these statutes. DOI insurance analysts will review forms for compliance under 215 ILCS 5/356z.4.

Additionally, issuers will be required to attest to DOI that they will segregate advance payments of federal premium tax credits and cost-sharing reductions to ensure that funds are not used for abortion services in the QHP application and during market conduct examinations. Compliance will be monitored through market conduct reviews, including financial exam auditors verifying that federal premium tax credits, etc. are segregated. The Market Conduct section of the DOI Consumer Unit will conduct the review for abortion law compliance.

Multi-State Health Plans (MSPs): While multi-state plans will be deemed eligible for the Illinois Exchange by the Office of Personnel Management (OPM), DOI regulators will verify that the MSPs certified by OPM meet state requirements. If any state standards, such as rating requirements, are not met, DOI will notify OPM. DOI and OPM will work together to address any compliance issues, including determining if DOI and/or OPM needs to take action to address the compliance issues. DOI will follow all future MSP guidance.

Stand-Alone Dental Plans: In general, stand-alone dental plans will be required to follow the same review processes and adhere to the same standards as QHP applicants. The stand-alone dental plan policy form checklist will include some adjustments, including different standards for reserves and deposits.

QHP Transparency Reporting: SERFF will be used to collect information from QHPs for transparency reporting, including information on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of denied claims, data on rating practices, out-of-network cost sharing and payment policies, enrollee cost sharing responsibilities at the service level, and enrollee rights under the ACA. These reporting requirements must be disclosed to DOI and made available to the public in plain language. Health plan information on file with DOI is discoverable under the Illinois FOIA statute, 5 ILCS 140.

However, consumer complaints are confidential per Section 926.40(b)(6) of the Illinois Administrative Code, which provides, “the complaint and all documents submitted with the complaint or in response to the complaint are deemed confidential and will not be released to third parties.”

Form Review: Plans offered in the Exchanges must be QHPs that meet certain federal requirements set forth in the ACA and subsequent regulations, as well as any additional QHP standards imposed by the State. The implementation of the ACA in 2014 will require additional resources to properly staff the form review process for QHP’s recommended to CCIIO to be included in the Exchange. DOI will maintain its regulatory authority for plan review with state and federal laws. The initial submission of the QHP application will include the policy forms which will be offered by the plan. The filing and any communication on the policy form will be conducted in SERFF or the HIX Vendor’s plan management solution.

Implementing the new QHP application process will require numerous policy form changes, and the Department will provide advice and support to plans on how to achieve the changes. DOI will issue directions to permit plans to file form language in an expedited and certified manner. These instructions will explain the use of Illinois’ QHP application template. This template will address compliance standards required by the ACA to be included in health policies and its use will be required as it will be leveraged for HIOS submission to CCIIO. Full directions and an explanation of the template will be included in a Company Bulletin.

The template will contain required provisions which must be included in the policy form in accordance with the ACA. The policy form will contain the following requirements:

- Essential Health Benefits
- Pediatric Dental Benefits
- Mental Health Parity
- Cost-Sharing Limitations (including FPL)
- Prohibition on Pre-existing Conditions
- Network Adequacy/Service Areas, including Essential Community Providers
- Clinical Trials
- Guaranteed Availability
- Guaranteed Renewability
- Enrollment Periods
- Termination of Coverage Provisions
- Grace Periods
- Waiting Periods

In addition to the federal requirements, the plans will need to include those required benefits under the state statutes. These will be provided in a checklist required to be submitted with the form filing. The QHP application will require the plan verify they have submitted both a Gold and Silver plan design, including additional child only plans or rates. This will be reviewed and checked by the insurance analyst who receives the filing.

Any plan which files a form filing with actuarially equivalent substitutions will be submitted to an actuary for review to determine compliance. Additionally, rate filings will be filed concurrently with the policy forms but will be submitted as a separate filing for review. The rate filings will be reviewed by an actuary in accordance with existing rate review procedures. These procedures have been established in response to the Rate Review Grant the Department received under the ACA.

4.2c – Capacity to collect, analyze, and if required, submit to Federal government for review of QHPs' plan variations for cost-sharing reductions, advance payment estimates for such reductions, and any supporting documentation needed to ensure compliance with applicable regulations and accuracy of the cost-sharing reduction advance payments.

Plans will submit QHP plan variations for cost-sharing reductions, advance payment estimates for such reductions, and any supporting documentation to DOI through SERFF. To facilitate the review of this information, DOI will be hiring additional actuaries (as noted in earlier sections), which be located in the Financial-Corporate Regulatory and Life Actuarial Divisions of DOI. These actuaries will review and analyze this information for accuracy and compliance with regulations. Once DOI approves of the QHP variations, it will use SERFF to transmit the information to the Federal government.

4.2d – Capacity to ensure QHPs meet actuarial value and essential health benefit standards in applicable regulations and guidance.

DOI plans to leverage the AV calculator that is being developed by CCIIO for the initial evaluation of whether a QHP's benefits are actuarially equivalent to the EHB benchmark. DOI will supplement this tool by hiring a Health Actuary and an Actuarial Assistant in the Financial-Corporate Regulatory and Life Actuarial Divisions of DOI (as noted in earlier sections) to review the essential health benefits for discriminatory plan design, especially in regard to benefit substitutions, service limits, and drug coverage. Staff will also review plans that do not use the CCIIO AV calculator and are certified by actuaries due to unique benefit design.

4.2e - Capacity to ensure QHPs' compliance with market reform rules in accordance with all applicable regulations and guidance.

Compliance with QHP standards will be checked when the policy forms are filed. Additionally, DOI will monitor complaints and conduct further investigations, in addition to scheduled market conduct examinations, if it appears that plans are not implementing under their submitted policies. This oversight process will include a notification of findings to CCIIO as a partnership Exchange.

4.3 - Plan Management System(s) or Processes – Exchange or appropriate State Agency uses a plan management system(s) or processes that support the collection of QHP issuer and plan data; facilitate the QHP certification process; manage QHP issuers and plans; and integrate with other Exchange business areas, including the Exchange Internet Web site, call center, quality, eligibility and enrollment, and premium processing. Evidence should include and/or address the following: 1) Brief description of the anticipated number of health plans expected to participate in the Exchange, and 2) Brief description of the collection method and applicable systems that will be used to support the business operations of Plan Management.

- ***Capacity to collect and analyze information on plan rates, covered benefits, and cost-sharing requirements pursuant to 45 CFR 155.1020 (4.3a)***
- ***Capacity to use plan rate data and rules for purposes such as generating consumer-facing premiums and determining the second-lowest cost silver plan for premium tax credit calculations (4.3b)***

Based on feedback survey results DOI received from major medical insurers that are currently licensed to provide health coverage in Illinois, DOI anticipates about 260 plans to be offered on the individual Exchange and about 260 plans to be offered on the SHOP. DOI expects these offerings to come from 16 different carriers.

4.3a - Capacity to collect and analyze information on plan rates, covered benefits, and cost-sharing requirements pursuant to 45 CFR 155.1020.

DOI will use SERFF to collect QHP issuer plan data, including plan rates, covered benefits, cost-sharing requirements, and other application requirements. However, while SERFF will be capable of tracking the confirmation of proper licensure and solvency, it will not support the basic workflow process for this evaluation. As a result, the building of an IT system to wrap around SERFF to provide additional plan management functionality, such as collecting data on performance and appeals, has been included in the HIX RFP.

Actuaries and health insurance regulators will use this new system to review QHP applications more efficiently through an automated workflow process. This system will also be leveraged for QHP application submission if the enhanced SERFF functionality is not ready in time. Data on DOI's recommended QHPs will be submitted to HHS for certification through HIOS.

4.3b - Capacity to use plan rate data and rules for purposes such as generating consumer-facing premiums and determining the second-lowest cost silver plan for premium tax credit calculations.

Capacity to use plan rate data and rules and for determining silver plan cost for premium tax credit will be achieved through a rules engine within the HIX system solution. Vendor proposals to build this system are currently being evaluated. DOI will share additional details with CCIIO after the completion of the procurement process.

4.4 - Ensure Ongoing QHP Compliance – The Exchange has the capacity to ensure QHPs' ongoing compliance with QHP certification requirements pursuant to 45 CFR 155.1010(a)(2), including a process for monitoring QHP performance and collecting, analyzing, and resolving enrollee complaints. Evidence should include and/or address the following: A brief description of approach to ensuring QHP compliance and monitoring of QHP performance, including any integration between Exchange and other State entities.

- ***Capacity to ensure QHPs' ongoing compliance with QHP certification requirements pursuant to 45 CFR 155.1010(a)(2) and Exchange operational requirements (4.4a)***
- ***Process to monitor QHP performance and to collect, analyze, and resolve enrollee complaints in conjunction with any applicable State entities (e.g., State Department of Insurance, consumer assistance programs, and ombudsmen) (4.4b)***

DOI will coordinate closely with CCIIO to ensure ongoing QHP compliance. This will include sharing QHP complaints, performance data, and other metrics, as well as communicating and coordinating actions taken to appropriately address QHP noncompliance.

QHPs will be required to report data on consumer complaints, length of time to pay claims, etc., as part of the NAIC Market Conduct Annual Statement. These reports will be analyzed and QHPs which have ratios outside the normal range will be subject to a more detailed review to determine if a market conduct exam is warranted. The Illinois Insurance Code also authorizes DOI to engage third party market conduct examiners to review QHP compliance and performance at the examinee's expense. DOI will also monitor complaints within the marketplace from consumers, Navigators, and others, which may trigger periodic, targeted market conduct examinations of QHPs. Market conduct examinations evaluate insurers' underwriting, advertising, marketing, and claims practice to determine whether they are performing according to the conditions and provisions stated in their policy contracts. The scope of such examinations will include compliance checks for maintenance of QHP certification requirements. As a plan management partner, DOI will share the results of such examinations with CCIIO.

SERFF will not include functionality for issuer account management and compliance with operational requirements, including ongoing communication with the carrier, issue tracking and reporting, appeals, operational and administrative data, dashboard reports, performance reporting, agent and broker activity, and market conduct. DOI plans to have the HIX Vendor build a new, electronic system to

increase efficiency by substantially delivering such functionality and eliminating current paper-based workflows.

In regards to integration between state entities, DPH will review HMOs for network adequacy and quality standards and make recommendations to the Health Products Division of the Consumer Unit based on their evaluation for DOI's consideration. DPH will use the electronic HIX system in this review process.

The DOI Office of Consumer Health Insurance (OCHI) will take the lead on collecting and resolving consumer complaints. Additionally, DOI will work with the Office of the Special Deputy Receiver to marshal the assets of companies in liquidation to cash and pay the cash to persons with claims against the liquidated company.

4.4a - Capacity to ensure QHPs' ongoing compliance with QHP certification requirements pursuant to 45 CFR 155.1010(a)(2) and Exchange operational requirements.

To ensure ongoing QHP compliance with QHP certification requirements, DOI will monitor complaints and financial standards; DOI will also conduct market conduct examinations. Complaints will be monitored by DOI staff and inquiries received may also be investigated. Additionally, financial monitoring, such as solvency strength tests, will take place monthly, quarterly, annually, and triennially. Furthermore, Level 1 reviews will be conducted every six months and more frequently if necessary and reviews will be tailored to the precise problems at issue. More comprehensive market conduct examinations will be conducted regularly and more frequently when warranted based on complaints, claim payment history, and other relevant factors that will be monitored by DOI through the QHP oversight process. The reviews will be paid for by the plans being reviewed.

4.4b - Process to monitor QHP performance and to collect, analyze, and resolve enrollee complaints in conjunction with any applicable State entities (e.g., State Department of Insurance, consumer assistance programs, and ombudsmen).

DOI OCHI will track and resolve consumer complaints. DOI currently monitors complaints by coding them by type of coverage, source of complaint (insured, attorney, health care provider, legislator, etc.), and reason for complaint and disposition. Complaints are reconciled with the carriers annually; this will be done on a complaint by complaint basis beginning January 1, 2013. Additionally, information is uploaded to the NAIC on a monthly basis. The complaint data is analyzed by the DOI cost containment staff and market conduct staff for trends that may indicate a market conduct exam is needed. It is also analyzed by the complaint unit when suspicion of a trend or market practice arises or when inquiries are received from areas such as the press or other states. DOI will monitor QHP complaints in the same manner.

Additionally, DOI will be able to monitor QHP performance via the OCHI phone tracking system which is currently being developed and via the electronic complaint system which will be enhanced in the near future. DOI will add new categories to the phone tracking system which will identify QHP related issues and will be able to run reports on those issues. Additionally, DOI will add coverage, reason, and contributing factor codes to the electronic complaint system to identify QHP entities and complaints

against them. These systems will allow analysis of calls, inquiries, and complaints based on company, type of coverage, reason, and resolution or disposition.

4.5 - Issuer Support – Exchange has the capacity to support issuers and provides technical assistance to ensure ongoing compliance with QHP issuer operational standards. Evidence should include a description of issuer technical assistance and support activities to be provided by the Exchange and examples where applicable.

DOI will provide technical assistance to carriers on an ad hoc basis. DOI will create a designated email box for QHP questions and will have DOI staff assigned to answering questions submitted through the email inbox directly with the carriers. DOI has effectively provided technical assistance in this manner for the implementation of past initiatives.

4.6 - Issuer recertification, decertification, and appeal of determinations – Exchange has a process for QHP issuer recertification, decertification, and appeal of decertification determinations pursuant to 45 CFR 155.1075 and 155.1080. Evidence should include: 1) Brief description of the process for transitioning enrollees to new QHPs in the event of a QHP decertification, including any differences specific to SHOP, and 2) Brief description of general approach for decertification, recertification, and appeal of decertification.

- ***Process for recertification of QHP issuers and QHPs including the annual receipt and review of QHP rate, benefit, and cost sharing information pursuant to 45 CFR 155.1020(c) (4.6a)***
- ***Process for decertification of QHPs and QHP issuers and a process for transitioning enrollees into new QHPs pursuant to 45 CRF 155.1080 (4.6b)***
- ***Process for QHP issuer appeal of a decertification of a QHP pursuant to 45 CFR 155.1080 and any necessary appeal of QHP certification determinations consistent with an applicable state laws or regulations (4.6c)***

4.6a - Process for recertification of QHP issuers and QHPs including the annual receipt and review of QHP rate, benefit, and cost sharing information pursuant to 45 CFR 155.1020(c).

DOI will follow federal standards and the federal timeline for recertification. DOI plans to accelerate the recommendation process to CCIIO for plan recertification by requiring plans to highlight any materially, substantial changes, defined as anything other than a cosmetic or stylistic change that modifies the contract or the way business is conducted on the application. Additionally, if there are any material changes which take place prior to the renewal process, the issuer will be required to notify DOI within 30 days to allow time for an appropriate review. As a plan management partner, DOI will notify CCIIO if these material, substantial changes alter its recommendation for plan certification.

4.6b- Process for decertification of QHPs and QHP issuers and a process for transitioning enrollees into new QHPs pursuant to 45 CRF 155.1080.

Throughout the year, regulators at DOI will monitor ongoing QHP compliance with certification criteria through complaint monitoring and random audits. DOI hopes to have a HIX Vendor with a system that aggregates issues identified by producers and Navigators, consumer complaints, market conduct findings, and financial status by leveraging multiple DOI databases to more efficiently track, categorize,

and identify trends. However, the exact functionality of this system will depend on the Vendor of the HIX RFP, which has not yet been selected.

If a plan does not meet one or more requirements, the Director of Insurance may revoke, suspend, or not recertify QHPs under the authority of the Illinois Insurance Code 215 ILCS 5/143. If a plan is decertified, DOI will notify the issuer. Criteria for decertification includes insolvency, financial noncompliance, unresolved sanctions, not adhering to corrective action plans, not providing DOI with required documents, and performance issues. Intermediate sanctions and corrective action plans may also be used as outlined within 215 ILCS 134/80 and 215 ILCS 134/85(f) for noncompliance that falls short of full decertification. Additionally, 215 ILCS 134/80 provides that if the DPH determines that a health care plan is not in compliance with the terms of this Section, it shall certify the finding and submit them to DOI. DOI shall subject a health care plan to penalties as provided in this Act. Section 215 ILCS 134/85 provides for the issuance of a C&D and a hearing. In the case of financial insolvency, HMOs are liquidated. QHP compliance can be monitored through market conduct exams and consumer complaints. DOI will use the Administrative Code hearing rule.

Enrollees in a decertified plan will have the option to choose a new plan under a special enrollment period. If a plan is leaving the market, the plan must help transfer members to a business with approximately equal networks and coverage.

4.6c- Process for QHP issuer appeal of a decertification of a QHP pursuant to 45 CFR 155.1080 and any necessary appeal of QHP certification determinations consistent with an applicable state laws or regulations (4.6c).

The issuer may request a hearing pursuant to 215 ILCS 5/402. Section 402 provides that the Director shall have the power to conduct hearings in addition to those specifically provided for. Such hearings will be conducted in accordance with 50 Ill. Adm. Code 2402.

4.7 - QHP Accreditation Timeline – A timeline for QHP issuer accreditation in accordance with 45 CFR 155.1045 and systems and procedures in place to ensure QHP issuers meet accreditation requirements (per 45 CFR 156.275) as part of QHP certification in accordance with applicable rulemaking and guidance.

As a plan management partner, DOI will follow the federal timeline for accreditation, which will be established by CCIIO in future guidance. The SERFF system will track if plans have been accredited and DOI will request that NCQA and URAC electronically advise the Department of any changes in QHP accreditation status.

4.8 - QHP Quality Reporting – Systems and procedures in place to ensure that QHP issuers meet the minimum certification requirements pertaining to quality reporting and provide relevant information to the Exchange and HHS pursuant to Affordable Care Act 1311(c)(1), 1322(e)(3), and as specified in rulemaking.

DOI will require each issuer that submits a QHP application to provide CAHPS data and any additional data specified in federal guidance for quality reporting and display on the Exchange. DOI will collect this

data through SERFF. DOI will not provide CCIIO with a link to additional quality data for plan year 2014, however, it will consider options for the collection and presentation of additional quality data for plan year 2015.

10.0 - Privacy and Security

10.1 - The Exchange has established and implemented written policies and procedures regarding the Privacy and Security standards set forth in 45 CFR 155.260(a) – (g).

DOI has included privacy and security language in all IES and HIX RFPs. DOI expects to complete draft policies and procedures by 4/30/2013. This date may change once a HIX system vendor has been selected. Illinois will comply with all federally mandated deadlines.

10.2 - The Exchange has established and implemented safeguards that (1) ensure the critical outcomes in 45 CFR 155.260(a) (4), including authentication and identity proofing functionality, and (2) incorporates HHS IT requirements as applicable.

In conjunction with the policies referenced in 10.1 above, DOI will direct its DDI vendors to implement appropriate safeguards and to satisfy the HHS IT requirements. Safeguards and HHS IT requirements will be incorporated into the initial set of requirements by 4/30/2013. This date may change once a HIX system vendor has been selected. Illinois will comply with all federally mandated deadlines.

11.0 - Oversight, Monitoring, and Reporting

11.1 - The Exchange has a process in place to perform required activities related to routine oversight and monitoring of Exchange activities (and will supplement those policies and procedures to implement regulations promulgated under the Affordable Care Act 1313).

11.1a - The Exchange has in effect policies and procedures for performing routine oversight and monitoring of Exchange activities

11.1b - The Exchange has in effect quality controls as part of oversight and monitoring of Exchange activities.

DOI will be responsible for activities related to routine oversight and monitoring of Illinois Exchange Partnership activities. The oversight of Illinois Exchange Partnership activities will comply with the Affordable Care Act (ACA) Section 1313, including:

- Maintaining an accurate accounting and analysis of all activities, receipts, and expenditures, and
- Providing periodic reports in relation to the activities undertaken by the Exchange to HHS as required; such as, enrollment statistics, consumer satisfaction reports, relevant audit reports and any required State and Federal reporting.

DOI will accept complaint information from the Office of Consumer Health Insurance (OCHI) regarding QHPs and will coordinate with CCIIO accordingly. DOI will also coordinate with CCIIO on the results of QHP market conduct examinations and any appropriate sanctions against QHPs that need to be taken to address noncompliance. DOI also plans to leverage SERFF to collect information from QHPs for

transparency reporting that will be shared with CCIIO, including information on claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of denied claims, data on rating practices, out-of-network cost sharing and payment policies, enrollee cost sharing responsibilities at the service level, and enrollee rights under the ACA.

DOI will develop a manual to identify the area accountable for completion of each Illinois Exchange Partnership business requirement and further identify staff area assignments and responsibilities to ensure proper supervisory oversight, including end to end process flows. Additionally, DOI will develop a quality management plan, change management plan, action item plan, and communication plan, with the assistance of its Design Management Team.

DOI is in the process of securing the services of a HIX System Integrator (SI) Vendor. As part of the HIX RFP, DOI has requested the selected vendor to develop and a quality oversight and monitoring process for all of the Illinois Exchange Partnership activities to assure coordination among the DOI divisions.

DOI will work with the HIX SI Vendor to develop a plan to identify and combat areas of fraud, waste, and abuse and report findings to HHS as a partnership Exchange. This plan will include developing internal controls and program integrity best practices and will be built in the HIX SI Vendor's system development plan. The HIX SI Vendors IT build will be managed through a requirements traceability matrix and a project plan that includes system dependencies, contingencies, risks, issues, and delivery dates. Further, all Illinois Exchange Partnership activity is subject to the supervision of lead DOI administrators, including the Director of DOI. As an executive branch agency of state government, DOI performance is subject to the review of the Governor's Office. DOI's Exchange Partnership duties will also be subject to adherence to the Memorandum of Understanding executed with CCIIO.

11.2 - The Exchange has the capacity to track and report performance and outcome metrics related to Exchange Activities in a format and manner specified by HHS necessary for, but not limited to, annual reports required by Affordable Care Act 1313(a).

CCIIO has indicated that future guidance will be released indicating the metrics that the Illinois Exchange Partnership will be required to report to CCIIO. Additionally, Illinois understands that the format, timing, and other requirements will also be included within that guidance. Illinois stands prepared to work with CCIIO in timely implementation of these requirements.
Additionally, DOI will develop performance and outcome metrics related to plan management and consumer assistance partnership activities. These will include:

- Number and type of QHP applicants recommended to CCIIO;
- Average time of QHP application review by DOI Unit;
- Number and type of errors and issues on QHP applications that result in denial or the need for carriers to resubmit the requirement or provide additional documentation;
- Carrier complaints and appeals by issue and type;
- Consumer and assister complaints about QHPs by issue and type;

- Enrollment success rate by assister, including automated enrollment versus requiring eligibility specialist intervention;
- Common application deterrents, as reported by assisters;
- Updated uninsured rate by geography and demographics; and
- Further metrics to be determined with DOI/Exchange leadership.

DOI will expand on these metrics when Illinois becomes a state-based Exchange and track additional measures such as enrollments versus applications; website workflow, including where shoppers drop out of the process; eligibility appeals by issue; call center response time; number of consumers receiving subsides and the level of subsidies, average employee contribution, coverage changes by individual across the Exchange and Medicaid, etc.

11.3 - The Exchange has instituted procedures and policies that promote compliance with the financial integrity provisions of Affordable Care Act 1313 (and will supplement those policies and procedures to implement regulations promulgated under the Affordable Care Act 1313), including the requirements related to accounting, reporting, auditing, cooperation with investigations, and application of the False Claims Act.

The Illinois Health Benefit Exchange follows GAAP Cash-Based Accounting Standards for its reporting of assets, liabilities, revenue and expenses. Its financial reporting is on an accrual basis. In addition, IL HIX follows all Federal regulations as outlined in its Cooperative Agreement awarded by the Department of Health & Human Services, including:

- HHS Grants Policy Statement
- 45 CFR Parts 74 and 92
- OMB Circular A-122

State mandated reimbursement and payment processes have been applied to each of the State's Affordable Care Act grants. All disbursements must be approved by the Grant's Authorized Representative before funds are drawn down from the Federal account through the HHS Division of Payment Management. Once released from the federal account, the funds are separately paid out through the State Treasurer's Office, a process requiring the submission of forms to the Treasury Banking and Warrant Divisions as well as the State Comptroller's Office. The State will continue to employ this thorough process for financial management. Because funds for each of the State's ACA Grants draw down into the same account, DOI has utilized Microsoft Excel to develop detailed accounting mechanisms to ensure against the improper attribution of expenses. Since receiving its first ACA Grant in August 2010, Illinois has complied with all State and Federal spending rules.

12.1 - The Exchange has executed appropriate contractual, outsourcing, and partnership agreements with vendors and/or State and Federal agencies for all Exchange activities and functionality as needed, including data and privacy agreements. Exchange contracting entities meet the requirements for eligible contracting entities outlined in 45 CFR 155.110.

Contractor	Services
CSG Government Solutions	CSG serves as the Project Management Office for the Integrated Eligibility System (IES), helping to fulfill the Work Plan requirements related to the IES within the Exchange IT Systems Core Area, including ensuring that the necessary federally required program activities are appropriately reflected in the IES project deliverables in compliance with all seven conditions and standards necessary for the enhanced Medicaid match of 90%.
Deloitte Consulting LLP	Deloitte produced research and a report providing detailed quantitative analysis of the state's uninsured and underinsured populations; quantitative analysis of the state's insured population by market segment; qualitative analysis of barriers to coverage; a qualitative and quantitative analysis of coverage affordability; future projections of the uninsured; coverage trends; a descriptive analysis of the state's insurance market; an analysis of the state's agent/broker population; and an estimate of the impact of new coverage options made available through the Affordable Care Act.
Deloitte Consulting LLP	The Illinois Department of Healthcare and Family Services retained Deloitte to implement an Integrated Eligibility System for Medicaid and the Exchange, as well as the State's SNAP and TANF programs.
First Data Government Solutions, LP	First Data is providing a three-member Design Management Team to assist the State with the implementation of Exchange activities. This includes supporting the development of functional and technical requirements for the State's Partnership and State-Based Exchanges as well as certain functions related to the overall management of the project.
Health Management Associates (HMA) (with sub-contractors Wakely Consulting Group and CSG Government Solutions)	HMA, Wakely, and CSG were originally retained to produce a Needs Assessment report detailing the costs, staffing implications, and infrastructure needs associated with an Exchange, the impact of an Exchange on the current consumer marketplace, long-term financing options for the Exchange, and options for the State to transition its existing public health program eligibility systems to the level of functionality required under the ACA. The Department of Insurance extended its contract with HMA and Wakely to provide more detailed research on

	Navigators and in-person assistance, qualified health plan certification requirements and procedures, the risk adjustment and reinsurance programs, various options for long-term Exchange financing, and Essential Health Benefits benchmark plan options.

13.3 - The appropriate State entity has appropriate agreements in place and capacity to manage and operate a Navigator program and to establish and operate an in-person assistance program for a State Partnership Exchange.

13.3a - The appropriate State entity has established or has a process in place to support, administer, and oversee (as applicable) aspects of the Federally-facilitated Exchange Navigator program consistent with the applicable requirements of 45 CFR 155.210, including ensuring that Navigators are adhering to the training and conflict of interest standards established by the Federally-facilitated Exchange and to the privacy and security standards developed by the Federally-facilitated Exchange pursuant to 45 CFR 155.260.

The Illinois Department of Insurance will administer and oversee all Navigator Program operations assigned to the State through the Illinois Partnership Exchange. The State's interpretation of federal guidance holds that CMS will select Navigator entities and award all grants, after which DOI would administer the program on an ongoing basis. DOI is well-prepared to take on administrative duties, with experience overseeing similar programs, including the Senior Health Insurance Program (SHIP) and producer licensing, as well as experience in providing direct assistance to consumers through the Office of Consumer Health Insurance (OCHI). All Navigator Program administrative operations under the SPE will be located in the Consumer Services Section of DOI's Consumer Market Division. The State will hire a Senior Program Director to oversee both the Navigator and In-Person Assistance programs. The Senior Program Director will have access to resources within the Department necessary to complete program objectives. Training services will be procured through a vendor. DOI will also work with the Department of Health and Family Services (HFS) to build on and leverage lessons learned from the All Kids Application Agent (AKAA) program and coordinate these DOI and HFS outreach programs. In the future, the Navigator and AKAA programs may be fully integrated under an Exchange Authority.

DOI has carefully studied the requirements of the program and assessed design options through a report prepared by Health Management Associates (HMA). The HMA report presented an overview and analysis of federal requirements for the program, including eligible entities, Navigator duties, conflict of interest standards, training, and funding. The report also offered recommendations for program implementation in each of these areas (though the State would not have administrative control over all of these functions under a Partnership Exchange). As part of the report, HMA solicited input from a diverse group of stakeholders, including government agencies with oversight of consumer assistance or producer programs, advocacy groups, business groups, health care providers, and insurance industry representatives.

The final report was posted to both the Department of Insurance website as well as the Governor's health reform website on July 6, 2012, and interested stakeholders and citizens were invited to comment through July 27, 2012. Additionally, the Governor's Health Reform Implementation Council solicited comment on the report at a public meeting on August 28, 2012. DOI is utilizing the report and public input from 50 separate individuals and organizations as guides in developing its approach to the administration of the Navigator program.

DOI is also in the process of contracting for a Navigator and Consumer Assistance Needs Assessment Report, which will gather additional demographic and geographic data on the uninsured and other populations likely to seek or benefit from the services of Navigators and other consumer assistance entities. The findings of the Needs Assessment report will help the State finalize its approach to the

Navigator program and other forms of consumer assistance as the ACA's new coverage provisions take effect by capturing more detailed information about the target population and informing necessary Navigator expertise. For example, the needs assessment will capture the geographic distribution and highest concentrations of the un- and underinsured in Illinois, key subpopulations that make up the un- and underinsured in Illinois (*e.g.,* age, income, education level, language, racial, ethnic, or cultural identity, prevalence of one or more disabilities, specific conditions such as substance use disorders, etc.), social service support systems currently engaged with these subpopulations, barriers to obtaining health insurance, and an analysis of the needs of the un- and underinsured by geographic distribution and subpopulation. When its duties under the SPE become clear, DOI will utilize funding received through its second Exchange Establishment Grant to obtain the services of a vendor to implement the training standards established by the federally facilitated Exchange (FFE).

Training

The final regulation on Exchanges and Qualified Health Plans requires states to establish a set of training standards for Navigators to ensure expertise in 1) the needs of underserved and vulnerable populations; 2) eligibility and enrollment rules and procedures; 3) the range of QHP options and insurance affordability programs; and 4) applicable privacy and security standards. While current guidance is unclear with respect to a state's role in Navigator training under an SPE, Illinois understands that CMS intends to issue training standards for State Partnership Exchanges and Federally Facilitated Exchanges in the form of sub-regulatory guidance at some point in the future, and that the State may have limited ability to supplement or contribute to the development of such standards. However, DOI obtained recommendations for Navigator training through the HMA report, which will be implemented to the extent possible under the Partnership. DOI encourages CCIIO to, at a minimum, allow supplemental State training to the federal training curriculum to ensure Illinois Navigators fully understand programs offered through HFS, including those that would and would not qualify as minimum essential coverage, and Illinois-specific private insurance market information.

The HMA report recommends that initial training take place in a classroom setting with in-person instruction, allowing Navigators to directly interact with trainers. Web-based training is proposed as an alternative if funding for in-person training is not available. In any case, Navigators will be required to pass an exam following the initial training to ensure that the content has been mastered and retained. Recertification will be required every 12 months in person or online, and will include refresher training and instructions on any newly implemented standards. As with the initial training, Navigators will be required to pass a test for recertification.

The content of the training will meet all federal standards contained in current and future regulation and guidance. The HMA report and public comments recommend including in the curriculum information related to commercial insurance, Exchange and Medicaid eligibility, helping consumers select a QHP that is right for them, including the needs of patients who suffer from rare and chronic conditions and diseases, post-enrollment consumer support (*e.g.,* provider billing questions), State-operated consumer assistance programs, formal grievance and complaint processes, coverage renewal, privacy and security requirements, needs of the uninsured and vulnerable populations, alternative safety net program options if insurance is still unaffordable for some individuals, and screening and referral for other public benefit programs (*e.g.,* SNAP and TANF) included in the Integrated Eligibility System. The planned Needs Assessment report described above will provide additional information on the state's uninsured and vulnerable population that will be used in developing training content.

Illinois received funding for the development of a Navigator training curriculum as part of its second Level One Exchange Establishment Grant. After receiving guidance from the federal government about its role in training and recommendations from its Needs Assessment, DOI will issue an RFP to obtain a vendor to provide training services. Staff in DOI's Consumer Services Section will oversee the development of training materials and presentations, and will establish the necessary relationships with the FFE to confirm that Navigators have completed trainings and passed required testing.

Conflict of Interest Standards

DOI will ensure that Navigators comply with all conflict of interest standards adopted by the FFE. DOI understands that such standards will cover both financial and non-financial considerations. As part of its oversight responsibilities, DOI will make the standards clear to Navigator entities and monitor compliance on a continuing basis through detailed questionnaires. Should the state have influence over the curriculum, conflict of interest standards will also be reinforced during training.

Privacy and Security Standards

DOI will ensure that Navigators comply with all standards related to the privacy and security of personally identifiable information (PII) developed by the FFE. DOI will confirm that Navigator entities understand and follow procedures established for the collection, use, disclosure, and destruction/disposal of PII; data quality and integrity standards; correction of information; individual choice; safeguards related to PII; and any other standards developed by the FFE relevant to Navigator entities. DOI will undertake all appropriate monitoring standards to ensure compliance, including questionnaires, audits, and inspections.

Oversight

If allowable under federal guidance, DOI plans to collect Navigator performance metrics including applications submitted, new enrollments, individuals eligible for Exchange subsidies or Medicaid, changes in enrollment levels over time, and outreach activities completed. If Navigators are selected to target a specific population (*e.g.,* homeless, immigrant, limited English proficiency, etc.), the number of individuals served within the targeted category will also be measured. There will also be a formal grievance and complaints process that tracks concerns at the individual Navigator level; this information will be collected through an online portal and/or DOI staffers. Similar to SHIP counselors, Navigators will provide performance data to Illinois on a monthly basis to allow for program monitoring; reporting frequency will be re-evaluated for future years. To provide regular feedback, performance data at the individual and program level will be provided to Navigators quarterly.

Timeline

A draft timeline for the State's Navigator Program activities appears below.

Date	**Activity**
October 2012	Finalize Contract for Needs Assessment
November 2012	Submit Blueprint Application

November 2012-January 2013	Conduct Needs Assessment
January 2013	Receive Approval or Conditional Approval of Blueprint
December 2012-January 2013	Develop Program Standards, Issue RFP for Training Services
January 2013-May 2013	Conduct Outreach to Encourage Navigator Applications
February 2013	Apply for Establishment Grant Funding
March 2013	Hire Senior Program Director
May-June 2013	Select Training Vendor and Approve Training Materials
June 2013	FFE Selects Navigator Entities
July 2013-September 2013	Navigators Receive Training and Certification
October 2013-December 2013	Navigators Assist Consumers during Open Enrollment
October 2013-December 2014	Navigators Provide Post-Enrollment Assistance and Assistance during Special Enrollment Periods
October 2013-December 2014	Program Oversight Conducted

13.3b - The appropriate State entity has established an in-person assistance program distinct from the Navigator program, and has a process in place to operate the program consistent with Federally-facilitated Exchange guidance, policies, and procedures.

As with the Navigator Program, the Illinois In-Person Assistance (IPA) program will be overseen by DOI's Consumer Services Section and may be fully integrated with the AKAA program under an Exchange Authority in the future. DOI understands in-person assistance program duties to include supporting consumers in filing an application, obtaining an eligibility determination or reporting a change in status, comparing coverage options, and selecting and enrolling in a QHP. As mentioned above, DOI is well-positioned to administer such a program due to its experience both overseeing similar programs (including SHIP and producer licensing) and providing direct assistance to consumers through its Office of Consumer Health Insurance (OCHI). DOI plans to contract with a vendor to conduct a Needs Assessment report identifying detailed demographic and geographic characteristics of Illinoisans currently uninsured or likely to need assistance as new ACA coverage options and affordability programs are implemented. DOI will use the results of the survey, as well as any additional guidance provided by HHS or the FFE, to finalize the design of its IPA program. DOI anticipates Navigators focusing on specific, hard-to-reach populations and IPAs focusing on uninsured and underinsured populations not covered by the Navigator program as well as the general public. The State will hire a Senior Program Director to oversee both the Navigator and In-Person Assistance programs. The Senior Program Director will have access to resources within the Department necessary to complete program objectives. Training services will be procured through a vendor.

Illinois will operate the IPA program with goals similar to the Navigator program: To help consumers access the expanded subsidized health insurance coverage programs and reformed and re-organized insurance markets that will result from the Patient Protection and Affordable Care Act (ACA). However, the IPA program will act as a supplement to the Navigator program and will not serve redundant purposes or populations. To distinguish the IPA program, Illinois will ensure that entities contracted through the program serve populations geographically and demographically distinct from the Navigator program. Oversight will be handled concurrently with the Navigator program and will be enforced as described above in Section 13.3a.

IPA entities will be commissioned to serve the individual market, as the State believes that producers already possess the expertise and resources to properly serve the small group market. DOI will work to ensure that producers receive training on how to use the Exchange on behalf of small business clients.

The State will select IPA entities through a competitive process, issuing a Request for Proposals (RFP) to solicit "bids" from applicants or establishing a competitive grant program. This will help the State to manage the number and quality of IPA entities. The State will likely allow the types of entities eligible for the Navigator program to apply for the IPA program, but will follow federal guidance to this effect. DOI will develop detailed criteria for Navigator entities following the completion of the Needs Assessment, but all selected entities will meet federal standards and will be judged based on demonstrated experience providing community based consumer assistance to the target population; strong communication skills, including cultural sensitivity regarding the target population; ability to understand complex topics and communicate information clearly to consumers; and knowledge of insurance affordability programs and commercial insurance.

The total number of entities approved will be dependent on the State's budget for the program. The State plans to apply for Establishment Grant funding to support its IPA program in February 2013 and currently plans to use a formula to account for federal Medicaid funding partially supporting the IPA program in the grant application. The HMA report estimated 65 to 215 grants being supported by a Navigator grant budget between $3 million and $10 million for the first year of operations, and the state's application for the IPA program will likely parallel this amount. Illinois will utilize a compensation structure of block grants with performance-based bonuses; this funding structure will be reviewed 18-24 months after awarding the first grant to evaluate its effectiveness. DOI believes this model best serves to provide necessary stability to support outreach and enrollment efforts central to the goals of the program while simultaneously incentivizing grantees to support consumers in choosing the most appropriate health plans given their specific needs and requirements.

Entities will be able to select among three separate levels of grants when applying for the IPA program. Level 1 Grants will offer up to $25,000 per year and will consist of organizations conducting activities within their own membership to identify potentially uninsured individuals and support enrollment into new coverage options. Level 2 grantees will receive between $25,000 and $75,000 and be expected to provide all Level 1 activities plus additional outreach and enrollment functions, including engaging in a set amount of (e.g., two per quarter) public or media events. To meet the outreach requirement, Level 2 grantees can use public media to promote awareness of the Exchange and other coverage programs, including conducting face-to-face presentations to the public, developing a dedicated enrollment event, participating in radio or television shows, and developing advertisements or public service announcements available electronically or in print. Level 3 grantees will receive $75,000 to $150,000 and be expected to provide all Level 2 activities plus develop and conduct large-scale outreach activities

to spread awareness about the Exchange and various assister programs using an array of public media approaches. Level 3 grantees could focus their efforts statewide and/or to specific targeted populations. Grantees would be required to propose a specific, strategic use of grant funding to conduct large-scale outreach campaigns, and would be expected to coordinate their activities closely with the state and federal government, both of which may be contemplating significant public education campaigns. Additionally, compensation and performance metrics will be appropriately varied depending on the population being served.

IPA entity performance will be judged on a broad array of factors, including applications submitted, new enrollments generated (taking into account time intensive and hard-to-reach subpopulations, including people experiencing mental illness, substance use disorder, or chronic homelessness), individuals eligible for Exchange subsidies or Medicaid, changes in enrollment levels over time, and outreach activities completed. As described above in Section 13.3a, a formal complaint process will be established for the program and will also factor into performance assessment, as will general consumer feedback from the individuals utilizing the IPA program and the State's continuing oversight of the program. IPAs will report monthly and receive regular feedback on their performance, in line with reporting expectations for the Navigator program.

To become certified as an IPA, all individuals from an entity receiving a contract must complete a one-time background check, complete the initial training program, and pass the training exam. To ensure consistent quality of service, IPA entities will be required to meet the same standards for training, privacy and security, and conflict of interest as those required of Navigator entities as described in Section 13.3a. The State will require IPA entities to receive the same federal web portal training offered to the Navigator entities.

A draft timeline for the State's IPA program activities appears below.

Date	**Activity**
October 2012	Finalize Contract for Needs Assessment
November 2012	Submit Blueprint Application
November 2012-January 2013	Conduct Needs Assessment
January 2013	Receive Approval or Conditional Approval of Blueprint
December 2012-January 2013	Develop Program Standards, Issue RFP for Training Services
January 2013-May 2013	Conduct Outreach to Encourage IPA Applications
February 2013	Apply for Establishment Grant Funding
March 2013	Hire Senior Program Director
March 2013-April 2013	Develop RFP/Grant Application for IPA entities

April 2013	Receive Grant Funding
April 2013	Issue RFP/Grant Application for IPA Entities
May-June 2013	Select Training Vendor and Approve Training Materials
June 2013	Select IPA Entities
July 2013-September 2013	IPA Entities Receive Training and Certification and Initial Payments
October 2013-December 2013	IPA Entities Assist Consumers during Open Enrollment
October 2013-December 2014	IPA Entities Provide Post-Enrollment Assistance and Assistance during Special Enrollment Periods
October 2013-December 2014	Program Oversight Conducted
January 2015	IPA Entities Receive Performance-Based Payments